STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005040	A. BUILDING: _____ B. WING _____	06/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICE	1850 STATE ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State hospital complaint investigation. Complaint number: IN00182153 Unsubstantiated: lack of sufficient evidence. Survey date: 06-22-16 Facility Number: 005040 Floyd Memorial Hospital and Health Services is in compliance with 410 IAC 15-1.5-5, Medical Staff, Indiana Hospital Licensure Rules. QA: 8/8/16 jlh	S 000		